NASSAU COUNTY
DEPARTMENT OF SOCIAL SERVICES
60 CHARLES LINDBERGH BLVD
UNIONDALE, NEW YORK 11553-3686

NASSAU COUNTY DSS FACILITY HOMELESS REFERRAL FORM

Date _____ Medical Facility Name _____

Name and contact # of Referral Source _____

PATIENT NAME _____ DOB _____

SS#* _____ MA/TA CIN, if active in <u>any</u> county _____

Patient's contact# where he/she can be reached _____

Does patient have legal status in the United States? ☐ Yes ☐ No

If patient has a case manager, please indicate case manager's name, agency, contact #:

_____

ADMISSION DATE* _____ PROPOSED DISCHARGE DATE* _____

_____

ADDRESS PRIOR TO ADMISSION* **_____**

Can patient return to this address? If not, explain* _____
Does patient have any friends/relatives he or she can stay with? ☐ Yes ☐ No
(If referring patient for temporary housing placement, potential housing resources in the form of friends, family, neighbors must be explored even if only available on a temporary basis.)

_____

INCOME/MONTHLY BENEFITS **(Indicate source and amount)* _____**
Last date income/monthly benefit was received * _____
How much does patient have available (cash on hand/bank accounts)?* _____
(*Patients referred must meet NYS Temporary Assistance eligibility requirements*)

_____

DOES PATIENT NEED FIRST FLOOR SHELTER PLACEMENT, WOUND CARE OR A REFRIGERATOR FOR MEDICATIONS? (specify) _____

DOES PATIENT REQUIRE SKILLED NURSING OR AIDE SERVICES TO RESIDE SAFELY IN THE COMMUNITY? _____ ***(If so, please explore a higher level of care such as a rehab, SNF or Assisted Living residence to meet the patient's needs.)***

DOES PATIENT HAVE AN ACTIVE SUBSTANCE ABUSE/ALCOHOL AND/OR MENTAL HEALTH CONDITION? (specify) _____ ***(If yes, is patient prescribed medication or in an out-patient treatment program for condition?)*** **☐ Y ☐ N**

HAS THE PATIENT BEEN ASSESSED AND CLEARED FOR SHELTER PLACEMENT? ☐ Y ☐ N

HAS PATIENT BEEN PRESCRIBED MEDICATION FOR A SERIOUS CONDITION/ILLNESS?

☐ Yes ☐ No ***(If so, please ensure they have been discharged with necessary medication and/or prescriptions. Please note if medication requires refrigeration.)*** **_____**

WHAT IS THE FOLLOW-UP TREATMENT PLAN FOR THE PATIENT? _____

Is patient a veteran? ☐Yes ☐ No

COVID-19 SCREENING QUESTIONS

IN THE PAST 14 DAYS:

1) **Has the patient tested positive for Covid-19? ☐Yes ☐ No**
2) **Has the patient experienced symptoms of Covid-19 that he/she cannot attribute to another health condition? (See the list of potential symptoms below) ☐Yes ☐ No**
    - *Fever or chills*
    - *Cough*
    - *Shortness of breath or difficulty breathing*
    - *Fatigue*
    - *Muscle or body aches*
    - *Headache*
    - *New loss of taste or smell*
    - *Sore throat*
    - *Congestion or runny nose*
    - *Nausea or vomiting*
    - *Diarrhea*
3) **Has the patient been in close contact (within 6 feet) for more than 10 minutes with anyone who has tested positive or has had symptoms of COVID-19 within the last 14 days? ☐Yes ☐ No**
4) **Has the patient spent longer than a 24-hour period in a state that is, or was before he/she left the state, subject to quarantine restrictions on travelers arriving in New York State? ☐Yes ☐ No**

E-MAIL REFERRAL TO:

HomelessHospDischarge@hhsnassaucountyny.us

Or fax referral to:

(516) 227-8744

Attn: Hospital Discharge Unit